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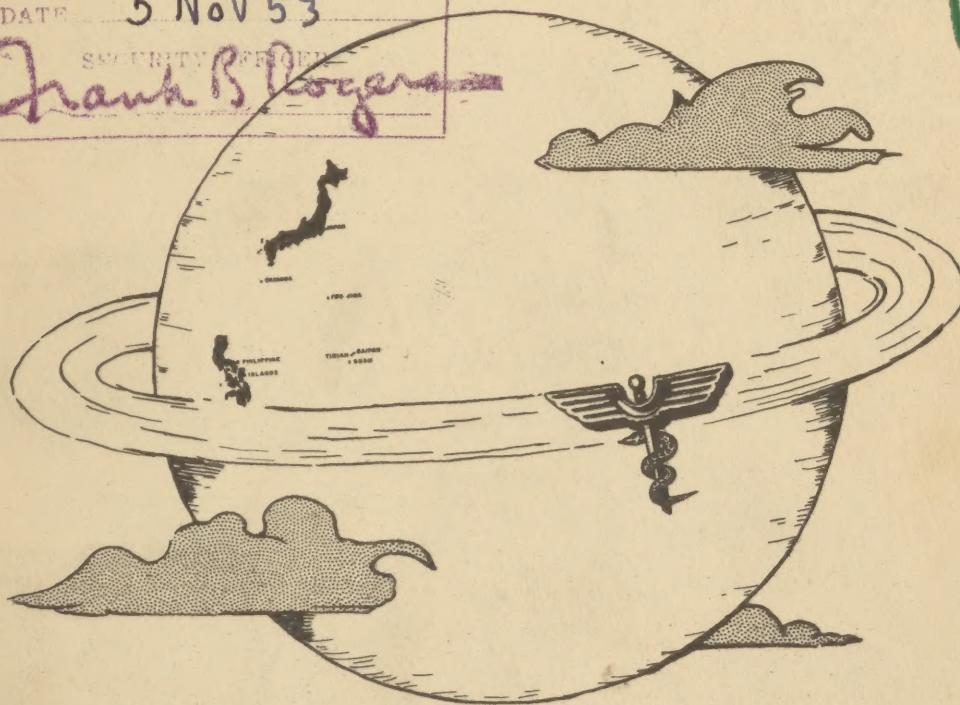
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MED SEC GHQ FEC

U.S. Army, Far East Command, Medical Section

VOL V NO 1
1 JAN 1950

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<i>Frank B. Rogers</i>	



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Organization of the Medical Section, GHQ, FEC

The following is a list of commissioned personnel currently assigned or attached to the Medical Section:

Major General Edgar Erskine Hume
Colonel Richard H. Eckhardt, MC
Lt. Col. Allen J. Blake, MSC

Chief Surgeon
Deputy Surgeon
Executive Officer

ADMINISTRATIVE DIVISION

Capt. Elvis E. Bates, MSC
WOJG Ernie L. Barker

Chief
Chief Clerk

PLANS AND OPERATIONS DIVISION

Lt. Col. Allen J. Blake, MSC
Major H. E. Archer, MSC
Captain Vincent I. Hack, MSC

Chief
Chief, Operations Br.
Chief, Publications and
Editorial Br.

SUPPLY AND FISCAL DIVISION

Lt. Col. E. W. Partin, MSC
Major Glenn C. Irving, MSC

Chief
Ass't Chief

PERSONNEL DIVISION

Lt. Col. Charles Raulerson, MSC
Captain Vernon H. Loisel, MSC

Chief
Ass't Chief

CONSULTANTS DIVISION

Colonel Irby J. Pollard, VC
Colonel Robert E. Blount, MC
Lt. Col. Arthur P. Long, MC
Lt. Col. Harlan H. Taylor, MC
Major Mildred I. Clark, ANC
Major Kermit E. Jones, MSC
Captain E. T. Brown, MSC

Veterinary
Medical
Preventive Medicine
Surgical
Chief Nurse
Sanitary Engineer
Medical Statistics Off.

DENTAL SURGEON

Colonel Harold G. Ott, DC

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GENERAL HEADQUARTERS
FAR EAST COMMAND
MEDICAL SECTION

SURGEON'S CIRCULAR LETTER

APO 500

NUMBER. 1

1 January 1950

PART I

ADMINISTRATION

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I. Organization of the Medical Section

Arrival in the Medical Section, General Headquarters, Far East Command: Colonel Harold G. Ott, DC, arrived from the zone of interior to assume the duties of Dental Surgeon, Far East Command.

II. Army Nurse Commended for Heroism During Typhoon



Captain Margaret A. Pate, ANC, attached to the 541st General Dispensary on Okinawa has been awarded the Commendation Ribbon for rescuing two children during the typhoon "Gloria" last July 23.

The award was presented by Maj. Gen. J. R. Sheetz, Commanding General of the Ryukyus Command, at a ceremony in which a detachment of troops from the 34th General Hospital and an Army band participated.

The commendation said that Captain Pate, "with complete disregard of her personal safety," climbed a steep hill for a distance of about 1,000 yards in winds reaching 175 miles per hour to aid Stephen and Julie Brown, 2 and 6 respectively, the children of 1st Lt. and Mrs. Patrick C. Brown of Riverside, California.

The children were caught in the wreckage of the quonset home occupied by Lt. Brown, an Air Force officer, and his family. Captain Pate administered first aid and with the help of their mother, removed the children to the 34th General Hospital.

Captain Pate, who is from Dillon, S. C., arrived on Okinawa in September 1948.

III. New Medical Journal to be Issued

A new publication, "U. S. Armed Forces Medical Journal," will appear this month, replacing present Army and Navy journals which contain articles of scientific and professional interest. There has been no similar Air Force publication.

Supplementing the new monthly publication will be the "Medical Technicians Bulletin of the

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U. S. Armed Forces," to be printed every other month. Its purpose will be to improve the technical proficiency of enlisted medical personnel.

Dr. Richard L. Meiling, Defense Department Director of Medical Services, will establish general policies for both the "Journal" and the "Bulletin." A new office, the Armed Forces Medical Publications Agency, assigned to the Navy's Bureau of Medicine and Surgery, will carry out operations functions.

First editor-in-chief will be the Navy member of a three-service editorial staff.

IV. Physical Examination for Permanent Promotion



Although annual physical examinations of Army officers and warrant officers are suspended during calendar year 1950, Change 7 to AR 40-100 states that a physical examination will be required for all Regular Army officers and warrant officers for permanent promotion during 1950.

In evaluating an individual's physical fitness for promotion in the Regular Army due regard will be given to the physical standards set out in AR 40-100 and AR 40-105, but these directives will not be interpreted as strictly as those for appointment or entrance on active duty. Consideration will be given to a record of satisfactory performance of general service over a reasonable period of time and to the individual's age, rank, branch and MOS.

V. Standard Form 89 (Report of Medical History)

Attention of all personnel concerned is invited to the additional provision contained in Special Regulations No. 605-25-1, Department of the Army, 2 November 1949, pertaining to medical examinations of applicants for Regular Army Appointment:

"5. Medical examination. . . . Standard Forms 88 (Report of Medical Examination) and 89 (Report of Medical History) required for this examination will be accomplished at a military medical installation having adequate facilities for accomplishing final type medical examination in accordance with AR 40-105. . . ."

VI. Value of Dramamine Retested



Dramamine, the anti-seasickness drug carried on U. S. Army transports, got another workout recently in medical tests involving approximately 600 seasick military and civilian personnel.

Conducted aboard six Seattle Port of Embarkation transports sailing to Japan and Alaska, the test program is reported to have indicated the speedy curative qualities contained in the drug. The Army Surgeon General's Office recorded results of the operation, conducted in the following manner:

Passengers were told to contact the ship's dispensary when seasickness occurred. Medical attendants gave dramamine to half of the stricken. The other half received, instead of dramamine, pills called "placebos", filled with a harmless mixture of sugar and starch compounds. No mention of the substitution was made to the passengers.

Of those given dramamine, 95% said they obtained relief; the remainder reported no improvement.

Receivers of the placebos were almost equally divided, 57% reporting relief and 43% saying the pills had produced no results.

Additional data were provided when the 43% who felt no relief from using placebos were given dramamine. All but 4% of this group found themselves "cured" by the drug.

Previous tests indicating the therapeutic value of the anti-motion drug were performed aboard a transport sailing from New York to Bremerhaven, Germany, in 1948.

VII. Public Health Training for Okinawans

During the latter part of 1949 a program of public health training was initiated on Okinawa by the Military Government to safeguard the health and well-being of Okinawans. The new institution located in the village of Futema was named the Futema Public Health Training School.

Seventeen Okinawan graduate nurses were chosen for the first class for specialized training as school nurses. On Okinawa the health of children is impaired by intestinal parasites, unbalanced diets and close contact with tuberculosis. It was pointed out that by training nurses to teach children proper health laws, the children in turn will ultimately act as teachers and interpreters at home.

In the first course the students will be taught to screen children who have upper respiratory infections, recognize lice infestations, make immediate discovery of skin diseases, and identify symptoms of contagious and infectious diseases. They will learn the methods of treatment for minor ailments; and for disease and injury which they cannot treat, they will have the facilities of the dispensary properly staffed with competent personnel.

Instructors will give lectures and hold demonstration classes. Students will live at Futema Center and in order to be helped financially as well as educationally will work in the schools nine months and spend three receiving special training.

VIII. Guam Medical Department Unit Makes Unification Work



During the latter part of 1949 the first unification of a Marbo Medical Department unit took place when the 22d General Hospital and the 16th General Dispensary of Marbo were closed down and the new Marbo Hospital Detachment was formed at the United States Naval Hospital on Guam.

The new Army organization attached to the Navy hospital is commanded by Captain Francis M. Mastrotta. The unit consists of eight Army doctors, who work side by side with Naval physicians, 14 Army nurses, a dietitian, and a physical therapist, 3 Medical Service Corps officers, one warrant officer, and 50 enlisted men who live and work along side the Navy Corpsmen.

The Navy allotted 200 beds to the Army and Air Force, and the use of all facilities at the hospital, the largest on Guam.

The medical commanders concerned were well satisfied with the unification and have expressed their desires that the goodwill and cooperation of the services will continue and will be an example for all future unification measures between all the services throughout the Armed Forces.

Army personnel at the Naval hospital are primarily there for Army and Air Force personnel, but will work with the Navy as needs develop. In turn, Naval personnel will help the Army.

Besides the medical personnel at the Naval hospital, there is a small staff to care for Army and Air Force administrative matters.

At the time of the closing of the 22d General Hospital, the new 359th Dental Prosthetic Detachment was formed at the Marbo General Dispensary and is in the same building that the old hospital dental section occupied. This new detachment will service all personnel of Marbo and the Air Force on Guam.

In the Marbo area dispensaries will take care of the immediate needs of Army personnel. At the Marbo General Dispensary there is a 30-bed ward for those who are under observation to decide whether admission to the hospital is necessary.

A patient under observation will remain at the dispensary only 24 to 48 hours. At the end of that time, he will be returned to duty or admitted to the Naval hospital.

The three other dispensaries serving Marbo are located at Wettengel Junction, at the Guam Army Port and at Perm Base.

The move to close the 22d General Hospital came in a recent order by the Secretary of Defense to unify hospital facilities in places where both Army and Navy general hospitals are in the same area.

IX. The Professional Educational Program in the Army Medical Department



Colonel Floyd L. Wergeland, MC, Chief, Education and Training Division, Office of the Surgeon General, presented a report on the Army's Professional Training Program at the Interim Convention of the American Medical Association held recently in Washington, D.C. The following extracts from Col. Wergeland's report on this program are published as a matter of interest to members of the Medical Corps.

"As you know, our initial planning was influenced by the critical postwar shortage of medical officers needed to support an Army almost five times pre-war strength. In 1946 there remained in the Regular Army Medical Corps only about half the number of officers we had before the war, and most of these had been on staff and administrative duties for several years. Phase One, then, called for the re-training of these men in professional duties, training the younger men who were entering the Corps, and securing enough doctors to adequately staff our medical installations. Although an acute personnel shortage still exists, I believe we are nearing the end of Phase One and are entering the second Phase, which is the long-range one of maintaining an alert and progressive Medical Corps, and providing training for younger men to meet the normal personnel attrition factor.

"The Education Program can be broken down into four main categories. These are: the Internship Program, the Residencies, Civilian Institutional Training, and the ROTC Program.....

"First - the Internship Program. This is conducted in two separate plans and we, for convenience, label them the Military Internships and the Civilian Internships.

"The Military Internship Program is a traditional one which has been in existence for many years, except for the period of the War. Under normal procurement operations it is the most effective instrument for obtaining Regular Army Medical Corps Officers in the grade of 1st Lieutenant. Experience has shown that approximately 80% of the participants elect to remain in the Regular Army.

"Internships in Army hospitals were started again in 1947 with 25 medical school graduates entering training..... Although a separate Medical Department was established for the Air Force last summer, we continue to carry Air Force personnel in our training programs throughout this Fiscal Year. Space allocations for future training have been tentatively agreed upon at a ratio of 80% Army, 20% Air Force.

"The Civilian Internship Program is a procurement measure, for the specific purpose of providing doctors for the many Medical Department assignments not requiring a specialist. You might call it a program of expediency. Under this plan, the intern is called to active duty as a Reserve Officer but takes his training at a civilian hospital of his own choice. Following internship, he serves a period of compensatory service in the Medical Department. This plan was instituted in 1948, and at the present time there are 271 interns participating. The program has been approved through Fiscal Year 1951 and 1952 with authorization for 300 trainees each year. It is doubtful, however, that all these spaces will be filled.

"Turning now to the Residency Program we find that this too falls into two categories--- Military Residencies and the so-called Civilian Residencies. The latter program, like the Civilian Internship, was an emergency procurement measure. Under this plan, a resident in a civilian hospital may apply for a Regular Army Commission and, if accepted, be called to active duty but remain at the civilian hospital until his residency is completed. This program was placed in effect early in 1948 to run for two years only, and was a stop-gap measure instituted for the sole purpose of alleviating the critical shortage of trained specialists. In this it has proved reasonably successful. Approximately 300 officers have entered the Regular Army through the program. Most of these will have completed their Residencies and will be on duty by 1951. This supplement to our own residency training program has been carefully controlled by specialty. It runs out next July and will not be continued.

"Military Residencies - The program of specialty training in Army teaching hospitals is the one where we have put most of our effort and the one where we have the most progress to report... Our formal residencies started in January 1947 when 190 men were assigned to training..... We now are conducting residency training in six General Hospitals in the United States plus Tripler in

Hawaii and Gorgas Hospital in the Canal Zone. All told we have 80 approved programs in 16 specialties. We are also carrying on the three-year Clinical Physicians Program (General Practice) at Madigan General Hospital.

"The number of spaces authorized in each hospital is carefully controlled. Four factors are considered in setting up space allocations. These are:

1. The over-all requirement for doctors in each specialty.
2. The amount of clinical material.
3. Availability of supervisory and teaching staff.
4. The number of applicants for training.

"All applications for residency training are screened by The Surgeon General's Professional Education Committee. This year when selections were made we called into Washington a representative from each of the teaching hospitals to assist the Committee. This proved a wise move and we will continue it in the future.

"Civilian Institutional Training--- In addition to the internship and residency programs, our educational plan gives selected medical officers opportunity for courses in civilian institutions throughout the country. These range in length from as little as three days to a full academic year.... This type of training is, we feel, essential. It will be continued within the limits of our budget.

"Another phase of our training program.....is our Medical Reserve Officer Training Corps. The Medical ROTC plan was re-established with the school year beginning in the fall of 1946. That first year ROTC units were organized at 20 medical schools with 490 medical students participating. This has increased until now we have Medical ROTC units at 49 medical schools and the total enrollment is over 4,000.

"The ROTC program is primarily aimed at building up our Medical Corps Reserve. We feel that it has been successful and has proved of mutual value to the Medical Department and the participating schools. To the individual medical student, the ROTC program gives some financial assistance, training in military medicine, and the opportunity of participating in a clinical clerkship type of summer camp at one of the Army General Hospitals. One big factor in the success of the ROTC program is The Surgeon General's policy in selection of Professors of Military Science and Tactics. When the ROTC program was re-instituted, permission was obtained to place in the PMS&T positions younger officers who could get residency or fellowship type training at the medical school where the unit was located. This has enabled us to assign high calibre men to these jobs, and has vitalized the ROTC program. If past growth is an indication, we can expect a continued expansion of ROTC enrollment.

"Now as to results of the program: The figures are not too impressive because of the short time the program has been in effect. As of the end of 1949, 170 medical officers will have completed formal residency training. Many more, of course, will finish during 1950 and the total will mount rapidly during the next two years. It is then that the greatest value of the program will become manifest, as more and more trained men become available for assignment throughout all our medical installations.

"Another result of the program is reflected in the increase in the number of Regular Army officers who are Diplomates of the various American Specialty Boards. From approximately 70, three years ago, the number is now more than 160. This list, too, will continue to grow as more men become qualified.

"The real effectiveness of the Professional Education Program cannot, however, be measured by statistical ratios or personnel tables. Its most striking result is shown in the stimulus it provides the individual officer to advance himself professionally. It is reflected in higher standards of patient care and in better morale throughout the Medical Department. We believe the results amply justify the effort and expense that have gone into it so far.

"We also feel that the program, or at least some phases of it, should be continued on a permanent basis. Of course, as our requirements are met, we will cut back on the number of people in training. This is already being done in several of the specialties. The matter of requirements is one that receives our constant study.

"One of our future plans calls for a greater emphasis on military medicine. We are now ready to start on a small scale what we feel is a very excellent course in Military Medicine. It will be held at the Research and Graduate School of the Army Medical Center and will be for five months.

"Now that we can be optimistic about the shortage of trained men, we are setting about putting the entire program on a sounder foundation. Even though we will reduce the number of trainees we certainly will not do so at the expense of quality. On the contrary, it is our intention that the programs be strengthened and improved. I am sure that constant improvement will take place as more and more well-trained men come out of the program and take over the instructional positions.

"Another plan we are giving much thought to is the extension of formal training to more Army Hospitals. We have found that the establishing of a formal program at a hospital has an almost immediate beneficial effect. This, I am sure, is a common experience in medical education. We would like to have some sort of formal program at all our large Army hospitals. The problem is how to accomplish this in the face of an overall reduction in training spaces."

X. Inclosure to Class 6 Inspection Sheet, WD AGO Form 8-134



The following information which is contained in a Department of the Army letter, subject: Inclosure to Class 6 Inspection Sheet, WD AGO Form 8-134, 5 December 1949, is published as a matter of interest to all personnel concerned.

"1. Reference is made to paragraph 17e 'Reporting class 6 inspections' of SR 40-950-1; AFR 160-22.

"2. It has been brought to the attention of this office that the preparation of the inclosure to the class 6 inspection sheet in the detailed manner now prescribed in the cited regulation frequently imposes an extremely heavy workload on preparing installations. It is believed that the work required in its preparation may not be fully justified in view of the rather limited use made of these completely detailed data in this office or headquarters through which the report may be transmitted. In order that preparing installations may reduce the workload to the fullest practicable extent and pending a contemplated formal rescission or revision of the Army Regulation requirement cited in paragraph 1 above, this office will accept without question any report received in which the class 6 inspection is reported as outlined in the following paragraphs.

"3. All products receiving a class 6 inspection, listed on the class 6 inspection sheet (WD AGO Form 8-134) and only those passed listed on the inclosure attached to the class 6 sheet. The destination of the products shown on the inclosure in the following manner:

- a. - Domestic (for products shipped to Department of The Army stations in the Zone of the Interior)
- b. - Overseas (for products shipped overseas - divided into major overseas command destinations as USARAL; USFA; USARCARIB; EUCOM; FECOM; USARPAC; TRUST; etc.)
- c. - Other organizations:

- 1 - Navy
- 2 - Air Force
- 3 - Marine Corps
- 4 - Veterans Administration
- 5 - Others

"4. A sample class 6 inclosure might appear as follows:

INCLOSURE TO CLASS 6 INSPECTION SHEET

PERIOD: November 1949

<u>Code</u>	<u>Pounds passed</u>	<u>Destination</u>
102	500,000	Domestic
	100,000	Overseas
	50,000 USFA; 50,000 EUCOM	
	50,000	Navy
	40,000	Marine Corps
103	30,000	Domestic

<u>Code</u>	<u>Pounds passed</u>	<u>Destination</u>
102	400,000	Domestic
	50,000	Overseas
	10,000 TRUST; 40,000 FECOM	
	20,000	Air Force

"5. Products rejected on a class 6 inspection reported in column 9 of the report as required by paragraph 17a 9c, SR 40-950-1, AFR 160-22.

"6. Stations located in an overseas theater report the destination of products, receiving a class 6 inspection on the inclosure to the class 6 inspection sheet, as 'overseas'. These destinations broken down into major commands as explained in paragraph 2b above. For example, if a class 6 inspection is performed on 50,000 lbs. of bacon at the Munich Quartermaster Depot (EUCOM) and 30,000 lbs. are shipped to the Berlin Military Post (EUCOM) and 20,000 lbs. are shipped to (USFA) it might show on the class 6 inclosure as follows:

304	Bacon, slab or sliced	50,000	Overseas
			30,000 EUCOM
			20,000 USFA

XI. Recent Department of the Army and FEC Publications



AR 615-366, 26 Oct 49 - Enlisted Personnel: Discharge; Misconduct (Fradulent Entry, AWOL, Desertion, Conviction by Civil Court); Sec II Physically Unfit Deserters and Absentees. Supersedes AR 615-366, 17 Dec 48, C-2, 17 May 49

AR 605-25, 2 Nov 49 - Officers: Appointment in RA. Supersedes AR 605-5, 10 May 48

AR 600-450, 7 Nov 49 - Personnel: Separation for Physical Disability

AR 40-100, 9 Nov 49, C-7 - Miscellaneous Physical Examinations. Supersedes DA Cir 375, 1948

DA Cir 120, 1 Dec 49 - Sec III, Physical Examination for Permanent Promotion, RA

SR 310-30-1, 1 Aug 49 - Military Publications: Organization and Equipment Authorization Tables.

Par 14 b (4) Hospital; Par 25 c, Medical and Dental Officers; Par 49 a, Medical T/O&E; Par 49 b, Medical T/O&E; Par 49 c, Medical T/O&E

SR 600-335-12, 7 Sep 49 - Pers: - Admission Card - General Prisoners. Par 6 v, Psychiatric Diagnosis

SR 750-605-6, 20 Sep 49 - Maintenance of Supplies and Equipment: Medical Maintenance Facilities. Par 3, St. Louis Medical Depot

SR 40-530-5, 7 Oct 49 - Medical Service: Hospital Patients Status and Transfer Reports from Hospitals in ZI. Sec II - Report of Patients from Overseas for Transfer by Debarkation Hospitals

SR 10-340-1, 10 Oct 49 - Corrected Copy. Organization and Functions: Department of the Army, Office of the Surgeon General

SR 32-160-40, 13 Oct 49 - Clothing and Equipment: Orthopedic Adjustments to Shoes. Supersedes Sec II, AR 30-2045, 24 Feb 47

SR 140-107-1, 20 Oct 49 - Organized Reserve Corps: Enlistment and Reenlistment - Enlisted Reserve Corps. Par 17, Physical Examination; Par 18 A 3, Report of Medical Examination

SR 615-90-1, 26 Oct 49 - Enlisted Personnel: Processing of Enlisted Oversea Returnees. Par 4, Physical Inspection and Verification of Physical Profile; Par 5, Immunization. Supersedes Memo 615-205-2, 20 Jan 48, including C-2, 15 Jun 48; C-3, 2 Feb 49

SR 625-5-1, 2 Nov 49 - Women's Army Corps: Appointment of Officers in RA. Par 7, Medical Examinations

SR 605-25-1, 2 Nov 49 - Officers: Appointment in RA. Par 5, Medical Examinations

SR 605-25-15, 2 Nov 49 - Officers: Appointment in JAG, RA. Par 8, Medical Examinations; Par 9b, Report of Medical Examinations

SR 605-25-20, 2 Nov 49 - Officers: Appointment of Chaplains in RA. Par 6, Medical Examinations; Par 8 b, Report of Medical Examinations

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SR 600-450-1, 7 Nov 49 - Personnel: Physical Evaluation; Hospitalization; Disposition; Separation for Physical Reasons

SR 40-590-20, 15 Nov 49, C-1 - Medical Service: Report of Patients on Seriously Ill List

SR 40-950-1, 25 Nov 49, C-1 - Medical Service: Veterinary Meat and Dairy Hygiene - General

PART II

TECHNICAL

SUBJECT

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XII. Notes Concerning Certain of the Communicable Diseases



(Measles, German measles, mumps, pertussis, chickenpox, streptococcal pharyngitis, scarlet fever, and diphtheria.)

Measures for the control of this group of infections are summarized in AR 40-210 and presented in more detail in TB MED 47. The following outline is in accordance with the provisions of the preceding references and is presented as an aid in the application of management and control procedures with particular reference to these diseases as they affect children.

MEASLES (Rubeola)

Source of infection. Secretions from the respiratory tract of infected individuals.

Mode of Transmission. Most commonly directly from person to person; possibly indirectly through articles freshly contaminated with respiratory tract discharges of infected persons. Highly communicable.

Incubation period. 10 to 11 days from exposure to onset of fever; 13 to 15 days from exposure to appearance of rash.

Period of communicability. During period of catarrhal symptoms, usually from 4 to 5 days before until 5 or 6 days after beginning of rash.

Control. Segregation of the patient from susceptibles for one week following the appearance of the rash (important for protection of the patient from secondary infection as well as for the prevention of spread to susceptible contacts). Susceptible familial contacts should be allowed to attend school for the first 7 days following the most likely date of exposure, but should be excluded for the remainder of the calculated incubation period. Schools should be notified of the occurrence of measles so that classroom contacts may be observed daily by the school nurse.

Specific protection. Immune Serum Globulin (Human) will provide passive protection against measles. This material is to be administered intramuscularly in a dose of approximately 0.1 cc per pound of body weight for complete protection and approximately 0.025 cc per pound for modification of the disease, the dose in either instance to be administered within 6 to 7 days of the initial exposure to be effective. (For protection of adults, see paragraph 16, TB MED 114.)

It is not possible to establish definite rules for the selection of those to be given complete protection and those for whom an attempt at modification of the disease is more desirable. However, it is recommended that in general susceptibles less than three years of age, who have had a definite exposure to measles, be given the protective dose. In addition, complete protection is considered advisable for exposed susceptible individuals with another disease or debilitating condition which might be seriously complicated by the occurrence of measles.

When applying specific protection against measles, it must be borne in mind that the complete

RESTRICTED

protection afforded by immune globulin is passive in nature and of short duration, probably not longer than three to four weeks. Modified measles will provide an active immunity but this immunity is not necessarily solid or permanent since second cases are known to occur in individuals who have previously experienced the artificially modified disease.

GERMAN MEASLES (Rubella)

Source of infection. Secretions of the upper respiratory tract of infected persons.

Mode of transmission. Directly from person to person, or possibly through articles freshly contaminated with respiratory tract discharges.

Period of communicability. 14 to 17 days from the onset of catarrhal symptoms.

Control. No particular control procedures indicated once the diagnosis has been established. Patients should be kept from school for 4 or 5 days after onset of rash.

MUMPS

Source of infection. Secretions from the mouth and possibly the nose of infected persons.

Mode of transmission. Most commonly by direct contact with a person with mumps.

Incubation period. 12 to 26 days, most commonly about 18 days.

Period of communicability. From 1 to 2 days before the development of distinctive symptoms until the salivary gland swelling subsides.

Control. Segregation of clinical cases from susceptibles; daily observation by the school nurse of classroom contacts.

PERTUSSIS

Source of infection. Discharges from the respiratory tracts of patients with the disease.

Mode of transmission. Direct contact with an infected person or rarely through articles freshly contaminated with respiratory tract discharges from infected individuals.

Incubation period. 7 to 14 days.

Period of communicability. Particularly communicable in the early catarrhal period, extending for about three weeks. Communicability usually negligible after this period even though spasmodic cough or whoop may persist.

Control. Segregation of cases from susceptibles during the period of communicability; daily observation of school room contacts by the school nurse. (Segregation of patient from susceptibles should not be interpreted to imply that the patient should be kept indoors throughout the entire period of the illness. The responsibility of contact with susceptibles, however, is still present.)

STREPTOCOCCAL PHARYNGITIS AND SCARLET FEVER

Source of infection. Discharges from the nose, throat or purulent complications of persons infected with Group A streptococcus hemolyticus.

Mode of transmission. Direct contact with infected individuals; occasionally by way of air-borne droplets or droplet nuclei; or, in the case of explosive outbreaks, the ingestion of contaminated milk or other foods.

Incubation period. Usually 2 to 4 days, occasionally up to one week.

Period of communicability. Extremely variable and may persist until the infectious process is completely healed; greatest during the acute phases of the infection and from chronic purulent discharges. Carrier states do occur.

Control. Segregation of all cases of acute streptococcal sore throat, with or without a rash,

until subsidence of the acute signs and symptoms; daily observation by the school nurse of classroom contacts; in the case of explosive outbreaks, investigation of possible source of contaminated food or milk. Dick test seldom if ever indicated.

CHICKENPOX

Source of infection. Material from the skin lesions, particularly in their early stages, and secretions from the respiratory tract of individuals with chickenpox. Highly communicable.

Mode of transmission. By direct person to person contact and at some distance by air-borne droplets or droplet nuclei; occasionally indirectly through articles freshly contaminated by infected persons.

Incubation period. 2 to 3 weeks; most commonly about 16 days.

Period of communicability. Highly communicable during the early stages of eruption; communicability continuing for about 1 week after the first crop of vesicles.

Control. Segregation of patient from susceptibles; daily observation of school room contacts by school nurse.

DIPHTHERIA

Source of infection. Discharges from diphtheritic lesions and secretions from the noses and throats of carriers.

Mode of transmission. By direct contact with a case or carrier, or indirectly by articles freshly soiled with discharges from such individuals; occasionally spread by contaminated food or drink, milk or milk products being the most likely media.

Incubation period. Usually two to five days.

Period of communicability. Variable, depending upon the presence of virulent organisms in the secretions from cases or carriers; usually two weeks or less, rarely more than four weeks; in chronic carriers may extend for several months.

Control. Isolation of patient until three cultures from the nose and throat taken at least 24 hours apart are negative, or if repeatedly positive, until the organisms present are demonstrated to be avirulent. Contacts should be inspected once or twice daily by a medical officer for five days following last exposure; inspections to include examination of the nose and throat. Nose and throat cultures of close contacts are indicated in some instances; intimate, (usually familial), child contacts and adult contacts whose occupation involves food handling or routine close association with children should be studied in this manner and their activities restricted until freedom from virulent C diphtheriae is demonstrated.

Specific protection. It is required that children in the Far East Command be immunized against diphtheria. In the presence of the disease, the immunization records of the children in the community should be examined and a single booster dose of toxoid administered to those children who had received toxoid or were demonstrated to be Schick negative more than one year previously. Immunization should be initiated in those instances where it had not previously been accomplished.

XIII. General Surgical Seminar*

Case # 1 "Imperforate Anus Newborn Infant"



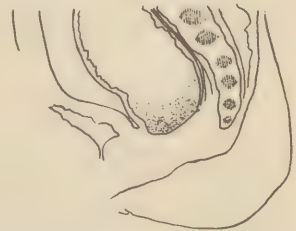
Infant, white, female, was admitted to the Tokyo General Hospital two hours after birth without any evidence of an anal opening, but with evidence of an anal dimple and intact sphincter muscles. Four hours after birth infant passed a small amount of meconium per vagina indicating a recto-vaginal fistula was present. X-

* Notes taken by Capt. J. F. Cason, on General Surgical Seminar presented at the Tokyo General Hospital. Comments are by Col. Warner Bowers, MC, Surgical Consultant, SGO, Washington, D.C.

rays consisting of flat plate of the abdomen were made on admission and at 12 hour intervals by the Wangenstein-Rice technique. At the end of twenty hours it was evident that we were dealing with a type 3 imperforate anus and the defect, a blind rectal pouch, was 2 cms. from the anus. At this time a perineal pull through operation was performed. Postoperative-ly infant did exceedingly well and was followed first at weekly intervals, then bi-monthly and monthly, at which time rectal dilations were performed. At the end of five months the index finger could be inserted with ease and patient was having normal bowel movements without any discomfort. An excellent result had apparently been obtained.

QUESTION: Col. Bowers will you please comment on this case.

ANSWER: Most cases of this type have some fistulous connection with the genito-urinary tract and are much more difficult to handle than this case. X-ray examination is important in order to determine how far down the gas goes and whether perineal operation is feasible. This case was ideal for a perineal pull-through for it is obvious that the rectal pouch is below the peritoneal reflection. The source of gas at this early period has been found to be mostly swallowed air. This was experimentally proven by Wangenstein in experiments on dogs in which he investigated air in the gastro-intestinal tract with and without continuity of the esophagus. Dr. Hoover at the University of Minnesota ran an analysis of the gas in obstructed patients and found that the flatus was very similar in composition to that of air and not gas products of decomposition. As soon as the diagnosis is made and the extent of the defect can be determined operation is indicated. Temporization is not advisable. The time interval in this case is about average for most cases. Since this is the third case in two years at your hospital it seems to me that you have had your quota of these cases, as the incidence is about one in twenty thousand. In most cases, as in your two previous reported cases, relief of the obstruction by colostomy is indicated. Later corrective surgery of abdomino-perineal type may be performed.



Case # 2 - "Diaphragmatic Hernia with Volvulus of the Stomach"

This 34 year old army corporal was admitted to the Tokyo General Hospital complaining of recurrent abdominal pains, vomiting and constipation, present for five days. Onset was following a very heavy holiday meal. Since that time he has been unable to retain any solid or liquid food for more than fifteen minutes when the stomach contents are vomited completely. He was previously hospitalized at this hospital five months before for fractures of the 6th and 7th ribs, anterior axillary line of the chest, left. A notation on his chart at that admission indicated that this patient had more than the usual amount of pain associated with fractured ribs. He required repeated intercostal blocks for relief of pain. A G.I. series was performed shortly after admission and x-rays are presented of this examination.

QUESTION: Col. Bowers, what is your clinical impression.

ANSWER: This is obviously a herniation of the diaphragm with volvulus of the stomach. I have lantern slides of an almost identical case. I have seen two such cases, one the result of an automobile accident and one following wrestling. In neither case was there acute obstruction. What were the findings at operation?

ANSWER: (Col. Anderson) - Operative approach was through a left subcostal Kocher incision. There was present a traumatic herniation of the diaphragm, approximately 10 cms. in length and about 2 cms, medial and posterior by a portion of the transverse colon and then the stomach. The stomach had rotated superiorly on its short axis and then twisted 120 degrees in a clockwise direction due to traction of omentum and transverse colon into the left chest cavity.

QUESTION: Col. Bowers, would you have used a trans-thoracic or transabdominal approach.

ANSWER: The surgical approach depends upon the training of the surgeon. One is as good as the other. In the operation vagotomy I prefer the transabdominal because I can then examine the viscera and determine the pathology being dealt with. I believe you are all familiar with the insertion of a catheter up into the chest relieving the suction and facilitating the reduction of the abdominal contents in these conditions. This of course will not help any where there is incarceration as there was in this case.

Case # 3 - "Traumatic Rupture of the Spleen"

This is a 19 year old soldier who was admitted to another hospital on 23 July 1949. Soldier stated that he began to have abdominal pain at 0600 in the left lower quadrant of the abdomen which later became generalized. Still later that same day he developed pain in both shoulders more in the left and extending up into the neck. He experienced difficulty in breathing and coughing. He was observed at the former hospital for possible encephalitis, hepatitis, relapsing pancreatitis and acute appendicitis. On admission to this hospital patient was in shock. He looked pale, apprehensive and presented air hunger. He was immediately given plasma with response. Examination of the abdomen revealed a doughy consistency, with tenderness and rebound tenderness. There was present a bruise on the left chest wall, and a positive Hoffstetter-Cullen sign. Further questioning revealed that this soldier had been struck on the left chest by the steering wheel of his truck when it hit a rut, 22 July 1949. He was 8.0 Grams and Hematocrit 26.1%. After proper pre-operative preparation and adequate blood available, spleenectomy was performed through a long left paramedian incision. Convalescence was uneventful. He is here today.

QUESTION: Col. Bowers, will you discuss this case and operative approach.

ANSWER: There are many red herrings in this case which led to erroneous diagnosis at the previous hospital. We have to keep ruptured spleen in mind more often in these apparently minor injuries. Shoulder pain with abdominal symptoms presented point to ruptured spleen. I prefer the left rectus incision all the way up to the costal margin. I do not believe that there is enough exposure with a transverse subcostal incision. I never use the T-incision. The first thing to do in these cases is to stop the bleeding by digital pressure on the pedicle of the spleen. One must be careful in this maneuver not to eviscerate the spleen.

QUESTION: Col. Bowers, how soon do you operate after patient has responded from primary shock.

ANSWER: Patient should get enough blood to raise the pressure at least to 90 m.m. of mercury systolic.

QUESTION: Col. Bowers, what other indications are there for spleenectomy.

ANSWER: Possibly only thrombocytopenia purpura and hemolytic crises. We also cannot forget spontaneous rupture in medical conditions, especially the malarial spleen. In medical conditions it is a problem for the internist and hemotologist primarily to decide.

Case # 4 - "Obstruction, Large Intestine, Postoperative"

X-ray pictures are presented here of a 61 year old white male who had repair of the right direct inguinal hernia under local novocaine block anesthesia. Thirty-six hours following operation he became distended and x-rays taken progressively for the next 24 hours showed marked dilatation (twice normal size) of ascending colon, transverse colon and descending colon down to the sigmoid colon where distention stops abruptly. Later pictures show involvement of the small bowel that is the terminal ileum. Barium enema the following morning, end 24 hours, shows no obstruction. Patient had no further trouble following barium enema.

QUESTION: Col. Bowers, what is your clinical impression.

ANSWER: (Prior to showing barium enema) Since you stated that he had normal peristolysis it is not paralytic ileus. Both the large and small bowel are involved showing incompetency of the

ileo-cecal valve. This must be a large bowel dynamic type of obstruction. It could be tumor, impaction. It is apparent that it has nothing to do with the operation which was performed on the right side. The next thing that could be done would be a transverse colostomy. The bowel still shows haustrations however and waiting as you did seems advisable. (After showing barium enema with no obstruction) This patient could have had a volvulus which was reduced by barium enema. He could have had spasm of the lower sigmoid. I have seen one case similar to this previously in which a transverse colostomy was performed and further surgery later showed no pathology. In this case the only deduction that could be made was that there was a spasm of the lower sigmoid.

Case # 5 - "Regional Ileitis"

This is the case of a 40 year old white female who was admitted to the Tokyo General Hospital with a history of recurrent chronic obstruction and a filling defect about the cecum. The tentative diagnosis was carcinoma of the cecum. She had had four previous abdominal operations. G.I. series at this hospital showed an inflammatory constriction at the ileo-cecal level. At operation the ileum was found to be involved in an inflammatory reaction with large mesenteric nodes. This segment of bowel was excised and an ileo-transverse colostomy was performed. Patient's convalescence was uneventful. She has gained in strength, bowel movements have reduced from 12 to 4 daily, but she has not gained weight. Pathological report was regional ileitis and talcum granuloma.

QUESTION: Col. Bowers, at original operation would you have performed a colectomy in addition to resection of the diseased bowel and ileo-colostomy.

ANSWER: I think you can afford to be conservative in these cases. It is important to get the patient over the immediate difficulty then more surgery can be performed if indicated. A shunting operation such as you have performed is often sufficient early. This case may have been entirely one of talcum granuloma.

QUESTION: Col. Bowers, is there any contraindication to removing the appendix in a young patient with regional ileitis.

ANSWER: No, not if the appendix is far enough away from the regional ileitis. If it is not, removal of the appendix is said to cause a fistula to develop.

Case # 6 - "Perforated Peptic Ulcer"

This x-ray presented positive evidence of bilateral pneumo-peritoneum. It is the case of a young soldier who was admitted to this hospital 12 hours after the onset of acute epigastric pain which occurred on awakening in the earlier morning hours. At time of admission his abdomen was not boardlike but there was marked muscle spasm and rigidity in the upper right abdomen. Because of the lapse of time he was treated conservatively by Wangensteen Suction, and parenteral fluids for a period of five days. He was also given chemotherapy and antibiotics. He responded nicely and was evacuated to the ZI for further treatment of his ulcer.

QUESTION: Col. Bowers, would you have operated this case.

ANSWER: I would not have operated upon this patient. I am in a process of change regarding the treatment of perforated peptic ulcer. I am not sure that it is ever indicated to operate upon these cases since the results are so good with a Wangensteen Suction. These patients usually perforate on an empty stomach, usually in the earlier morning hours, when there is excess acid present from night secretion. This acid peptic erosion results in the perforation. A highly acid empty stomach is really sterile biologically. The reaction on the part of the patient is chemical from the HCL. If we place a Wangensteen Suction in the stomach and keep it empty we prevent further acid from penetrating into the peritoneal cavity and the perforation heals over. We do just this with operation. I think it is bad to consider these patients with acute ulcers not qualified for service. I do not think that excision of the ulcer in these patients is ever indicated. I have only seen one patient that had multiple perforations, and he had three. It is not a common occurrence. Perforation in these cases is an erosion phenomena from peptic acid digestion. In the older age group with decrease or hypoacidity or where perforation is secondary to carcinoma of the stomach, surgery is indicated, but this is a different situation for here one has bacterial contamination. I do not see the logic of using chemotherapy or antibiotics in perforated peptic ulcer of the young age group for there is no bacterial infection, it is a chemical reaction.

XIV. Plaster of Paris in Orthopedics - Capt. E. C. Grale, ANC, 35th Sta. Hosp., Kyoto, Japan



Plaster of paris is indispensable to the orthopedist. It provides firm adequate protection in immobilization and unlike wooden or metal splints which become loose and require readjustment, remains in position for weeks, if correctly applied. Its malleability while hardening makes it the ideal substance for use in the immobilization of the trunk or limbs and in the correction of congenital deformities.

For the successful application of a plaster of paris cast by the bandage method, all necessary materials which include one or two buckets of water, a pair of large bandage scissors, a plaster knife, padding material (sheet wadding, flannel bandages, stockinet and felt), pieces of basswood or aluminum for reinforcements and an indelible pencil for marking dates and other information, should be on hand. If the hospital does not have a modern orthopedic table, the patient's pelvis can be supported with an inverted bucket, a box being placed under his back, shoulders and head. The sink in the plaster room should have a trap with copper screening to prevent clogging of the drain pipe and the floor should be covered with rubber sheeting or canvas since it is impossible to prevent plaster of paris from dripping. With everything in readiness to insure that there will be no interruptions, the process of applying the plaster cast is begun.

The skin over and around the area to be cased should be cleansed thoroughly without rubbing or shaving to prevent possible irritation. A piece of stockinet may be drawn over the affected area. One or two layers of sheet wadding are applied beginning at the lower end of the affected area, extending upward with several extra turns being added around the top and bottom to be cased. If there are any open wounds, or skin irritations, or if increased swelling is anticipated, additional turns of sheet wadding should be added. Felt, which should always be autoclaved before use to eliminate the possibilities of anthrax and tetanus, may be placed over bony areas to provide extra protection.

In applying the plaster bandages the part nearest the skin must be smooth to insure comfort. To avoid irregularities and ridges, a reinforcement strip should be made. A plaster reinforcement is made of successive lengths of dripping wet plaster bandage rubbed together on a board or table top. This strip of plaster is laid over the anterior or the posterior portion of the limb with the plaster bandages being applied over it. To avoid constriction of the limb, the plaster bandage should not be pulled as it is applied, but should be rolled and pushed around. Care should be taken to avoid creases and spiral reverse turns. If the direction of the bandage must be changed, a tuck can be made to avoid constriction. As it is applied, the cast should be rubbed and molded constantly to make it solid, strong and to conform to the contour of the limb. This rubbing and molding should continue until the plaster hardens. The plaster must be trimmed to the web of the toes and fingers so that the circulation can be watched. The padding at the top and the bottom of the cast must be turned back and fastened with a few extra turns of plaster bandage. This protects the skin and prevents it from chaffing. The patient should not be moved until the cast has set. A fan or therapeutic lamp is useful for drying plaster of paris especially if the weather is humid.

Difficulties and errors during and after plaster of paris applications can usually be avoided by a few simple details. Good results can be obtained only with satisfactory material. If the plaster of paris bandages are rolled too tightly or contain an excessive amount of plaster of paris powder they cannot get wet completely. If left in the water for a long time, the plaster of paris becomes hardened and must be discarded. If the plaster is rolled too loosely it will telescope upon removal from the water. Care should be taken to remove the bandages horizontally from the bucket of water to prevent telescoping. When the water becomes too saturated with plaster sediment, a fresh bucket of water should be used. The bandages should not be squeezed until ready for use; handling prevents complete soaking. Also, to prevent these bandages from drying too soon, the water should not be expressed until the surgeon is ready to apply them. Sodium chloride should never be added to the water as it shortens the setting time of plaster and makes the cast rough and brittle.

If good materials are used and the plaster of paris has been applied properly the base will be smooth. A broken or improperly applied cast is so uncomfortable and troublesome that it is best to apply a new one rather than spend the time and material patching something which will never fit satisfactorily.

Pains accompanying plaster treatment usually indicate infection, providing the plaster cast has not been bivalved as soon as it has hardened and pressure from edema is symptomatically ruled out. With a severe infection there is pain although this is not an indication for removing the cast. A sudden rise in temperature is not expected during the first few days after a compound fracture is immobilized and plaster of paris is applied. A rise in temperature usually indicates cellulitis or extensive wound infection. If gas bacillus infection or gangrene occurs the plaster cast should be

removed immediately to restore the proper surgical treatment.

If there is a profuse discharge there may be residual infection. Even if there is profuse discharge which discolors the cast, the cast should be left from two to three weeks before changing. There is no satisfactory treatment for offensive odors that develop in closed cast treatment of compound fractures, with soft tissue infection of osteomyelitis. In most cases, fresh air is the only solution to this objectional feature.

When changing casts, it is important to prevent reinfection by contamination of wounds. At this time strict aseptic precautions should be used.

Plaster of paris cast in the treatment of osteomyelitis is a simple but important procedure. The cast is used not only for immobilization of the affected bone but also the surrounding soft tissue. The above procedures are essential because of the extensive involvement of the soft structures which accompany the fractures. Inflammation produces an increase of lymphatic circulation, thus resulting in edema in the injured area. The lymphatic circulation depends to a large extent on muscular activity. Placing the muscles at rest reduces the rate of flow of lymph and thus the infection tends to become localized. To provide an adequate immobilization the cast should not only include the joint above and below the point of injury but extend beyond the joints with the limb held at position of physiological rest. The amount of traction used should be sufficient to reduce the fragments and to hold them in position. Separation of the fragments by overtraction is common cause for non-union.

The follow-up care of the plaster of paris cast is essential. The cast must be kept dry. Plaster must be protected from water and urine, the moisture not only softens the plaster, but an offensive odor may result from fermentation of the starch in the crenoline. Plaster can be water-proofed with shellac; this is especially useful on infant casts. When the bedpan is used the back rest of the patient in the plaster cast is raised sufficiently to prevent water from seeping under the cast. The skin under the cast must be kept as dry as possible. The patient should be turned freely in hot weather for complete airing and drying, and for ventilation. Boards placed under the mattress will make a firm and more comfortable bed thus preventing the edges of a heavy cast irritating the skin. Frequent observation of the patient for pressure sores, skin irritation and edema is important. If the cast becomes infected with body lice or bed bugs, it must be removed and another applied, if condition of patient warrants, otherwise insecticides are in order.

Trimming the cast is essentially important for the comfort of the patient. Every splint should have its edges rolled back, or if the cast is thick and hard, the edges can be beveled with the plaster knife. The padding beneath the cast is pulled forward over the edges of the cast and made secure with a few extra turns of plaster.

If after 24 hours following application of the cast, the patient complains of pain under the cast, it may be that swelling is causing local pressure; the only exception to this rule is pain which normally accompanies a severe injury or operation. Thin and debilitated patients frequently develop pressure pain over bony prominences. The frequent points of necrosis are: the spinous process, the sacrum, the iliac crest, the olecranon process, the lower end of the ulna, the proximal end of the thumb, the head of the fibula, the petilla, the malleolar, the heels and the proximal end of the great and little toes.

The toes and fingers should be checked for subsequent swelling and should remain uncovered. If they become cyanotic and cold the plaster circulation has been retarded. When this occurs the cast must be spread immediately to prevent gangrene. If severe swelling occurs two or three days following an operation a wound infection must be suspected and the cast should be opened for inspection. Slight swelling may be relieved by elevation of the limb. Cutting away at the plaster cast because of swelling is merely a temporary measure for the exposed portions also become edematous and the sharp edges of the cast irritate the skin. Pressure caused by ulcerations occurring at the edge of the plaster cast can usually be relieved by bending back the cast edge with a pair of plyers.

Pressure sores may occur under the cast from ridges, insufficient padding or remaining in the recumbent position over a long period of time. Unless the pressure is relieved necrosis of the tissue follows. When necrosis occurs the pain subsides somewhat as the nerve endings become less sensitive. If this condition continues the plaster sores can be detected by their characteristic odor and brownish discoloration of the cast. Care should be taken to prevent decompression of the plaster cast especially over the sacrum and the heels. The accumulation of moisture in these areas may result in softening of the plaster cast and permit subsequent ulcerations.

Windows are cut into casts to provide extra room for expansion over the chest and the abdomen

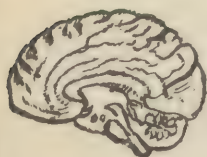
to aid in breathing and allow for after meal distension.

Patients who wear plaster casts require special attention from the nurse and the assistants. Prolonged rest without a knee support to the able leg will cause hyperextension of the knee joint resulting in poor body alignment and undue fatigue. Movement of the fingers and the toes should be encouraged as a simple exercise and as an aid to prevent muscle fatigue.

In applying a walking cast on the outpatient, an iron foot support is fastened to the cast with an additional plaster bandage. The walking iron must be placed in relation to the heel so that the patient will bear weight on the foot naturally.



IV Subdural Hematoma - Comments made by Dr. L. E. Daniels, Associate Professor of Neurology, University of Colorado, at the 35th Station Hospital, Kyoto, Japan



The subject of subdural hematoma should be of interest to surgeons as well as to medical men. No condition involving the head is more simply treated than subdural hematoma, but the diagnosis, on the other hand, can be exceedingly tricky. I have heard all the arguments against the diagnosis but when on the operating table, when the dura is out and blood pours out all the arguments fall flat.

The most frequent site of the rupture of subdural hematoma is in one of the tributary veins of the sinus sagittalis superior and is generally of the oozing type which probably explains the interval frequently observed. These clots are frequently huge. They may cover almost any part of the brain but are more common over the frontal region. There is a proliferation of granulation tissue within the encapsulation. In most cases the contents are fluid. One very characteristic finding is the presence of bile pigment on the under surface of the dura as the hematoma is exposed. The blood has an almost chocolate or oily appearance. One item which has been the subject of greatest debate is increasing compression of the brain, probably due to the osmotic pressure exerted by the protein products from the decomposition of the blood. In fact it has been proved experimentally that the contents of the hematoma have a high osmotic pressure.

If the patient is stuporous when you first see him, it may be impossible to get a history of the injury. That latent interval is extremely valuable diagnostically and in some cases more or less likely. Sooner or later the patient usually has a headache then becomes drowsy and finally stuporous, but may come out of the stupor and give medical attendants a false sense of security. The variability of symptoms and even clinical signs must be borne in mind. One man in Denver was told he had a headache only because he didn't want to work; after that he was found dead in the bathtub. The autopsy revealed he had a S.B.H. He had that besides his psychosis.

I am reporting here on a group of 24 cases which I have seen in my practice up until the

summer of 1946. Most of the patients were middle age or older although four fell in the adolescent group. I had no young adults in my group and I am especially proud of the aged group because they all recovered. It is very important to know that subdural hematoma can be caused by what appears to be a very trivial injury. In only twenty-one cases are there histories of injury. In seven the injury seemed to be trivial and in seven more, I assume, the patients had experienced cerebral concussion since there appeared to be a transient disturbance of consciousness at the time of injury, with prompt recovery. Two of the patients had subarachnoid hemorrhage. Sometimes there is a hemorrhage into the subarachnoid space and sometimes there isn't. Some people think S.D.H. is less likely than S.A.H. Nothing can be further from the truth. There is no reason why one can't bleed into S.D. as well as into S.A. space. Some cases have little or no unconsciousness, in others, the state of unconsciousness is prolonged which indicates cerebral contusion as well as concussion. There were only two who had immediate symptoms of an alarming sort and those cases are rather interesting so I shall present a thumbnail history of them.

One case is that of an elderly lady who struck her head against a shelf. Evidently she did not lose consciousness because she cried out. Her daughter rushed out and helped her to bed. Fifteen minutes later her left side was paralyzed. A doctor was called in who arrived in time to observe her left pupil dilate. Up to this time you might say it was epidural hematoma, but she recovered consciousness. Evidently there was a sudden increase in intracranial pressure; then her condition became stabilized. I saw her the next day entirely conscious. Here I predicated hematoma on the left side because of the localizing sign of the dilated hemiplegia in spite of the pupil which was also on the same side.

Another case was that of a boy who was hurt in the middle of January 1943 and thereafter had headaches. Four weeks after he was hurt he was bumped in a baseball game and became dizzy but did not lose consciousness at once. Within an hour he suddenly became stuporous and for several hours could not be brought out of it. Then his mental condition cleared for several weeks except for pains in the head. On examination there was hyperactivity of the knee and ankle jerks; the protein was up and on that basis the diagnosis was made and hematoma successfully drained. Here again there is rapid spread of blood into the subdural space, none of which caused loss of consciousness.

One patient suffered multiple injuries of the head. He was brought to Denver by air and was very stuporous when he was admitted at noon. He was operated on that evening. He had bilateral hematoma. Next morning he was sitting up in bed kidding the nurses and bemoaning the fact that he had no recollection of his only plane ride.

There was a complete latency of symptoms, in one instance of 71 days and another of 112 days among the cases I have included in this group. In those, as far as could be determined, for those periods, the patients experienced no symptoms whatsoever and in the other group relative latency of symptoms very mild from periods ranging from 10 to 98 days.

Of great importance are character changes. A previously well-behaved person may become very obscene. That wasn't particularly apparent in my series. There were only two actually in coma. Fluctuation of symptoms was observed only six times. It probably occurred more often but is only a matter of record in six cases. One patient, who was in a stupor when I first saw him, when seen by the surgeon was so free of symptoms that the surgeon wasn't very keen about operating. This man did have hematoma.

Physical and neurological examinations can reveal very little. There was one patient who was no mentally slow that we could not find a thing when he was checked. Then in the case of a man of 76 where there was such a paucity of findings that I turned to his daughter who was a trained nurse and said I couldn't find anything wrong with him, that he was just acting like an old man, her reply was "but he's been that way only since he was hurt."

As for the clinical signs, we found hemiparesis and reflex changes in nineteen cases. There would be sometimes, but not always, ocular palsies and slow pulse. We often found nothing on first examination, but later those signs could come out. Stiff neck is very common but stiff neck can be caused by an increased intracranial pressure.

In sixteen cases, the hematoma was on one side only and in three contralateral, where supposed to be, and in four others there were contralateral reflex changes and positive Babinski. Of the two presented, both contralateral, one of those had papilledema too, but the first had cerebellar tumor. However, he was in a very euphoric mood and extremely facetious. Everything seemed to him to be awfully funny. It appeared that he had a tumor of the front lobe, but operation revealed hematoma.

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When there is expanding lesion changes pushing the brain over to the opposite side, the opposite cerebellar or cerebral peduncle is compressed against the edge of the tentorium causing the hemiparesis or bilateral reflex changes to appear, hence the importance of exploring both sides in these cases.

In bilateral cases, bilateral reflex changes in two cases developed. Two others, bilateral changes were not seen. In one of those cases the hematoma on the other side wasn't found on the first operation, although both sides were picked up later.

As to the ocular palsies, it may seem strange that a hematoma lying over the top of the brain would cause paralysis of the eye muscles, but this is the way it seems to happen. As the expanding clot presses down on the cerebral hemisphere it herniates into the tentorium which compresses the third cranial nerve or frequently the sixth cranial nerve. The sixth cranial nerve can be involved in any case of intracranial pressure and hence oculomotor palsy is not of great localizing value.

Spinal fluid pressure is very important. The spinal fluid can be normal and the protein content can be normal, hence neither can be against the diagnosis.

A preoperative diagnosis of S.D.H. was made with varying degree of accuracy in eighteen cases. Of some cases there was considerable doubt but I thought the patient should be given benefit of doubt. In two instances there was no history of injury but diagnosis was made because the patient looked like other patients with subdural hematoma. There was something peculiar about the patient's appearance that others commented on. There was a blank expression on the face, there was stiffness of the neck, positive Babinski and because he looked like another man with a S.D.H. he was operated on and made good the diagnosis as a verified hematoma. One patient was dying when admitted and a proper history wasn't obtained. In one, no history of injury was elicited but a diagnosis of subdural hematoma should have been made.

Post-operative course is rather interesting. The only two women in this series were quite drowsy and stuporous for about a week or ten days after surgery, but recovered fully.

Some patients had Jacksonian seizures with aphasia after operation. Another one had abortive seizures, two patients in this series were older. One of the older patients had grand mal seizures and was confused mentally for a while but then cleared up and the last I heard, he is doing fine. Three patients died. One because he was dying when admitted and expired within fifteen minutes. The second who died was a patient I saw years ago when I was merely a hospital resident and didn't have much to say. He was explored on one side. At autopsy the hematoma was found on the other side. Then the surgeon explored one side the brain didn't seem to be under tension at all. The surgeon concluded there was no point in exploring the other side. If he had explored the other side he would have found the hematoma and the patient would have lived. The third patient who died was a case of a boy who developed some type of intracranial infection in the days before the antibiotics. He had been under the care of a general surgeon rather than a neurosurgeon.

The trick of making a diagnosis is to keep a patient under observation if there is any doubt and to keep your mind open. Also, do not go against the diagnosis; it is better to open a few heads unnecessarily than to find subdural hematoma on postmortem examination.

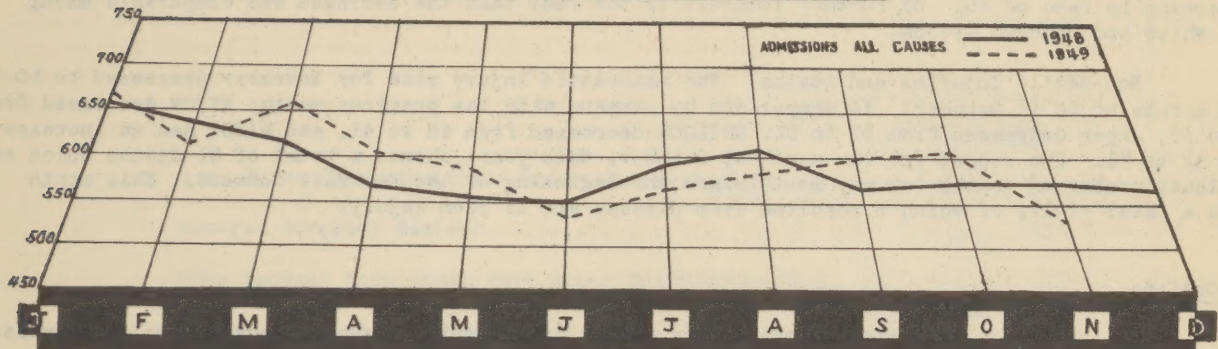
Professional Consultant to Tour Far East Command

Dr. Walter M. Bartlett, Professional Consultant in Internal Medicine will arrive in the Far East Command during the month of January. He will visit Army Medical Department Installations on Guam, the Philippines, Okinawa and Japan, in that order.

PART III

STATISTICAL

HEALTH OF THE COMMAND



Admission rates per 1000 troops per annum for the four-week period ending 25 November 1949 were as follows:

	FEC	JAPAN	MARBO	PHILCOM	RYCOM
All Causes	530	570	326	361	440
Disease	479	518	255	321	408
Injury	50	52	71	41	32
Psychiatric	8.1	8.8	5	11	4.7
Common Respiratory Diseases and Influenza	59	69	55	32	11
Primary Atypical Pneumonia	3.1	3.8	0	0	1.3
Common Diarrhea	2.8	2.5	1.2	6.8	4
Bacillary Dysentery	.17	.1	0	2.3	0
Amebic Dysentery	.08	0	0	0	.67
Malaria, new	.76	.88	0	0	.67
Infectious Hepatitis	4.5	5.3	2.5	4.5	1.3
Mycotic Dermatoses	2.6	2.8	6.2	0	0
Rheumatic Fever	.84	1.1	0	0	0
Venereal Disease	159	161	41	117	229

The admission rate for all causes among troops of the Far East Command for the month of November decreased from 609 for the previous month to 530. The lowest rate for the Far East Command prior to this rate occurred in June of this year, at which time it was 539. In comparison, the rate for November of 1948 was 570. Approximately 40% of the decrease from the month of October is attributable to a decrease in venereal disease rates.

The non-effective rate of 18 for November remains the same as for the previous two months. Other than for PHILCOM which has an unusually high non-effective rate due to Philippine Scout TB patients, all commands were 15 or less. In comparison, the non-effective rate for November 1948 was 21.

DISEASES:

Common Respiratory Diseases and Influenza: The rate for common respiratory diseases and influenza continues at an unusual low rate of 59. This represents a decrease of one from the previous month. The rates for the individual commands are as follows: Japan 69, MARBO 55, PHILCOM 32, RYCOM 11. PHILCOM's and RYCOM's rates decreased 50% or more from the previous month, whereas Japan remained the same and MARBO increased from 23 to 55.

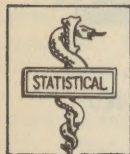
Malaria: The malaria rate for the Far East Command decreased from 3.2 in October to 1.4 in

November. This is the lowest malaria rate since the inception of the Far East Command. There was a total of 17 cases, of which 15 occurred in Japan and one each in RYCOM and PHILCOM. The case reported from PHILCOM was recurrent malaria. The one case from RYCOM and eight of the fifteen cases reported from Japan were primary.

Venereal Diseases: The total venereal disease rate shows a decrease for the second consecutive month. The rates for September and October were 206 and 196, respectively, as compared to 159 for this month. Japan and PHILCOM were the principal contributors to the decrease, each showing a decrease in rate of 45. Of further interest is the fact that the decrease was comparable among both white and colored troops.

Non-Battle Injuries and Deaths: The non-battle injury rate for November decreased to 50 from a rate of 53 in October. In comparison by command with the previous month, RYCOM decreased from 38 to 32, Japan decreased from 57 to 52, PHILCOM decreased from 46 to 41, and MARBO had an increase from 42 to 71. The report for the month of October, this year, showed a total of 21 deaths which was the least number of deaths for any month since the beginning of the Far East Command. This month shows a total of 17, of which 6 resulted from disease and 11 from injury.

Evacuation:



Tabulated below are the number of patients evacuated from the major commands to the ZI during the four report weeks in November and the number of patients awaiting evacuation as of 25 November 1949:

	BY AIR	BY WATER	TOTAL	PNTS AWAIT EVACUATION
JAPAN	69	218	287	143
MARBO	12	2	14	18
PHILCOM	19	0	19	0
RYCOM	44	40	84	0
FEC	144	260	404	161

Evacuations of military personnel per thousand strength for the period of 29 October to 25 November were as follows:

JAPAN	2.3	PHILCOM	2.8
MARBO	1.1	RYCOM	3.7
FEC	2.4		

Hospitalization:

The bed status as of 25 November 1949 was as follows:

	Total T/O Beds Auth.	Total T/O Beds Establ.	Total T/O Beds Occupd.	% Auth. T/O Beds Occupd.	% of Establ. Beds Occupd.
JAPAN	4,600	4,265	1,839	40	43
MARBO	125	125	96	77	77
PHILCOM	1,250	1,250	651	52	52
RYCOM	500	443	219	44	49
FEC	6,475	6,083	2,805	43	46

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The Chief Surgeon extends an invitation to all personnel of the Medical Department to prepare and forward, with view to publication, articles of professional or administrative nature. It is assumed that editorial privilege is granted. Copy should be forwarded so as to reach the Medical Section, GHQ, FEC, not later than the 10th of the month preceding the issue in which publishing is desired.

Capt. Vincent I. Hack, Editor